

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1693

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01665

Reg. Dist. No. 190

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge Rural</u> TOWN <u>Elkridge</u>		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u> TOWN <u>Elkridge</u> STREET ADDRESS (If rural, give location) <u>Box 222 Elkridge Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary Edna</u> (Middle) <u>Bealmeier</u> (Last) <u>Miller</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 4 1893</u>	9. AGE last birthday <u>72</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>	
13. FATHER'S NAME <u>Lucianus Cole</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mrs Ruth Stueck Box 2194 Elkridge 27 Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of Rectum Dec 1946

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

General Carcinomatosis 6 mo

(c)

Secondary Anemia & Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct, 1954, to Feb 4, 1955, that I last saw the deceased alive on Feb 4, 1955, and that death occurred at 11:20 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb 7 1955</u>	<u>Headwaters Memorial Park</u>	<u>Harvey</u>	<u>Howard</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Feb 7 55</u>	<u>E. Bird Williams</u>	<u>Dr. W. H. Davidson Laurel Md</u>		

B.

BUREAU V. S.

FEB 10 1925

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01666

Reg. Dist. No. 191

Item 2, File 6177 2-25-55 et

1. PLACE OF DEATH COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		LENGTH OF STAY (in this place) 7 mos		CITY (If outside corporate limits, write RURAL and give nearest town) Middletown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor				STREET ADDRESS (If rural give location) Monte Bellie Hosp. R.F.D.	
3. NAME OF DECEASED (First) EDNA (Middle) J. (Last) BUCHANAN		4. DATE OF DEATH February 12, 1954			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Jan 7 1875	9. AGE last birthday 80 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Broad Run Md.	
13. FATHER'S NAME John H. Grove		14. MOTHER'S MAIDEN NAME Laura V. Rudy		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT Miss Effie C. Grove	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 421.4				(a) Chronic valvular heart disease			
Antecedent cause(s)				(b) Dehydration		6 months	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 1, 1954 , to Feb 12, 1954 , that I last saw the deceased alive on Feb 11, 1954 , and that death occurred at 10:15 m., from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS Ellicott City Md 21035		DATE SIGNED 2/15/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 2/15/55		NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		LOCATION (City, town, or county) (State) Hagerstown Md.	
DATE REC'D BY LOCAL REG. Feb 15, 1955		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Andrew K. Coffman		ADDRESS Hagerstown Md.	

Feb. 17, 1955

P. B. E. L.

BUREAU V. S.

FEB 23 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1685

01667

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge (Rural)</u>	
TOWN <u>Elkridge</u>		TOWN <u>Elkridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rear of 2019 Towson ave</u>		STREET ADDRESS <u>Rear of 2019 Towson ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Fannie</u> (Middle) <u>Catherine</u> (Last) <u>Cooper</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 27, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Harrisburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Stoneifer</u>		14. MOTHER'S MAIDEN NAME <u>Heldelbrida</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr Joseph Cooper Elkridge 27 Mar</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chor. Myocarditis & decompensation

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes mellitus(c) General Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

2 mo10 yrs10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1, 1955, to Feb 21, 1955, that I last saw the deceasedalive on Feb 21, 1955, and that death occurred at 10:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

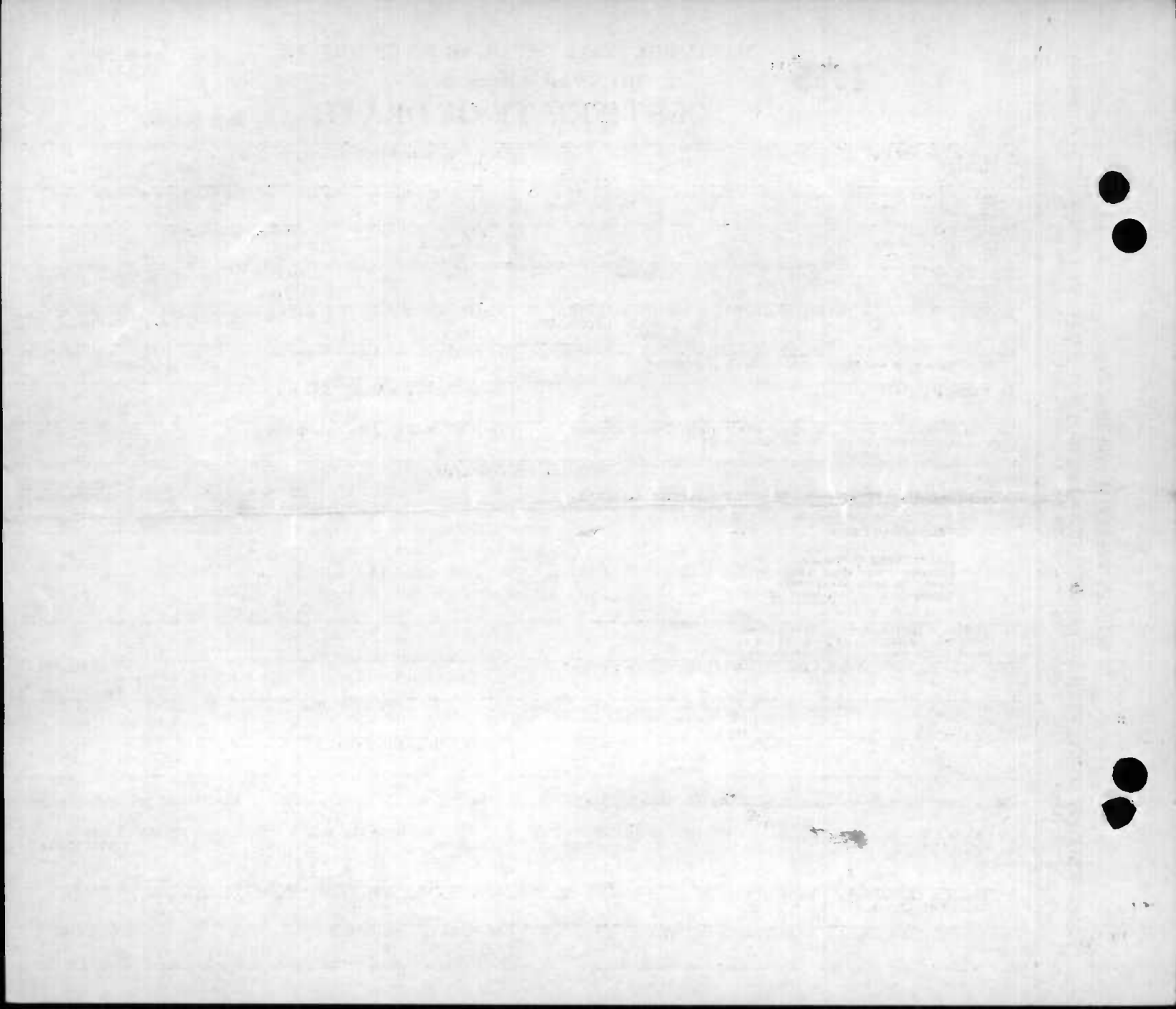
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 24, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Baust. Cemetery</u>	LOCATION (City, town, or county) <u>Union Bridge, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>2-23-55</u>		REGISTRAR'S SIGNATURE <u>AW Hall</u>		24. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons, 4985 York Road, Balto. 12, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1686

CERTIFICATE OF DEATH

Reg. Dist. No.

01668

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ellicott City</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor</u>				STREET ADDRESS (If rural give location) <u>115 W. Mulberry St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lauran Dorman</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Feb. 26, 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 14, 1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. Book Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME: <u>John Dorman</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Langesdale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Lorena Gagger, 1624 Mt. Royal Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>450.0 arteriosclerosis, generalized; Sen-</u>						2-3 yrs	
ANTECEDENT CAUSE (B) <u>ility; Urinary tract</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>infection.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-19, 1955</u> to <u>2-26, 1955</u> that I last saw the deceased alive on <u>2-19, 1955</u> , and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Taylor</u>				DATE SIGNED			
M. D. <u>Ellicott City, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery, Baltimore, Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>2/28/55</u>		REGISTRAR'S SIGNATURE <u>Alfred Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc. 1217 St. Paul St.</u>		ADDRESS	

THE UNIVERSITY OF CHICAGO

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THE UNIVERSITY OF CHICAGO

1687

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u>	STATE <u>Anne Arundel</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor</u>		STREET ADDRESS (If rural give location) <u>Annapolis</u>	
3. NAME OF DECEASED: (Type or Print) (First) <u>EDITH</u> (Middle) <u>N.</u> (Last) <u>JOHNSON</u>		4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>Unk. 1879</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Edward Rogers</u>		14. MOTHER'S MAIDEN NAME: <u>Unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Marrie Kleeman Wlen Murnie, Md.</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443X Immediate cause (a) <u>Pericard hemorrhage</u> DUE TO		2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Recurrent HCV disease</u> DUE TO		10 days
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1, 1955, to Feb. 17, 1955, that I last saw the deceased alive on Feb. 16, 1955, and that death occurred at 5 PM from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) ADDRESS Cedar Bluffs DATE SIGNED Feb. 19, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/19/55</u>	<u>Cedar Bluffs</u>	<u>Annapolis, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>Feb. 19, 1955</u>	<u>John B. Loughman</u>	<u>JOHN M. TAYLOR & SONS</u>	<u>Annapolis, Md.</u>

Feb. 24, 1955 Per. B. E. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1965

BUREAU V. S.

1688

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Howard</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Prince George</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>near Fulton</i>	LENGTH OF STAY (in this place) <i>3 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>College Park</i>	<i>14</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Simons Rest Home</i>		STREET ADDRESS (If rural give location) <i>7504 Princeton Avenue</i>	<i>✓</i>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Ella</i>	(Middle) <i>H.</i>	(Last) <i>Kirkham</i>	DATE OF DEATH: <i>February 27 1955</i>
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>March 27, 1872</i>
9. AGE last birthday: <i>82 yrs.</i>		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS.: Hours <i>0</i> Min. <i>0</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife own home</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Howard Co Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>Philip T. Beall</i>		14. MOTHER'S MAIDEN NAME: <i>Ann Amelia Penn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS: <i>4710 Harwich Rd</i>		<i>Mrs Robert Grimes College Park, Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Chronic myocardial failure</i>			<i>1 week</i>
ANTECEDENT CAUSE (B) <i>arteriosclerotic heart disease</i>			<i>2 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec. 28, 54</i> , to <i>Feb. 27, 55</i> , that I last saw the deceased alive on <i>Feb. 27, 1955</i> , and that death occurred at <i>11:55 A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Charles S. Whitaker</i>		DATE SIGNED <i>2/28/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY OR CREMATION <i>St Paul's Cemetery</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3-1-55</i>		REGISTRAR'S SIGNATURE <i>Marie A. Whitaker</i>	
24. FUNERAL DIRECTOR <i>De Witz & Son</i>		ADDRESS <i>Dorvaldian Lane, Md</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 2 1955

RECEIVED

VS. 10X4227396

RECEIVED

BUREAU V. 2

MAR 22 1955

RECEIVED

01671

1690

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 195

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Jessups</u> <u>rural</u>				TOWN <u>Jessups</u> <u>rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>One Spot</u>				STREET ADDRESS (If rural, give location) <u>One Spot</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		5. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.			
CHARLES MC KINLEY NELSON		2-25-55 19					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs. Months Days Hours Min.			
Male	Colored	Single	10-18-1954				
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
None		None		Howard County, Md			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Russell Purnell Nelson				Shirley Mitchell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Shirley Mitchell Nelson, Jessups, Md			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>916.0 Immediate cause (a) <u>Second and Third Degree Burns of upper 1/2 of body</u></p> <p>Antecedent cause(s) (b) <u>-</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>-</u></p>				instant	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>none</u>		<u>none</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State)	
		<u>Jessups</u>		<u>Howard</u> <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>25</u> <u>1955</u> <u>10 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>House caught fire with children in it.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Ernest E. Bunting</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/28/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>2-28-55</u>		<u>One Spot</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Frank Shipley</u>		24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>	
				ADDRESS	

1004182405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 3 1955

RECEIVED

1691

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01672

CERTIFICATE OF DEATH

Reg. Dist. No...191

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Columbia Road		STREET ADDRESS (If rural, give location) Columbia Road	
3. NAME OF DECEASED (Type or Print) TALTON JOHN PURKEY		4. DATE OF DEATH (Month) 2 (Day) 14 (Year) 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-13-1913
9. AGE last birthday 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
11. BIRTHPLACE (State or foreign country) Tenn		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Flaner Purkey		14. MOTHER'S MAIDEN NAME Ellen Purkey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. 217-18-1738	
17. INFORMANT AND ADDRESS Lilly Purkey, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b).....

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan 14, 1955**, to **Feb 14, 1955**, that I last saw the deceasedalive on **Feb 14, 1955**, and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2/16/1955	Libanon Good Shepherd	Libanon Ellicott City
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 14, 1955	John B. Loughman	F. C. HIGGINS & SONS	Ellicott City, Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 18 1955
BUREAU V. 2

1692

CERTIFICATE OF DEATH

Reg. Dist. No. 191

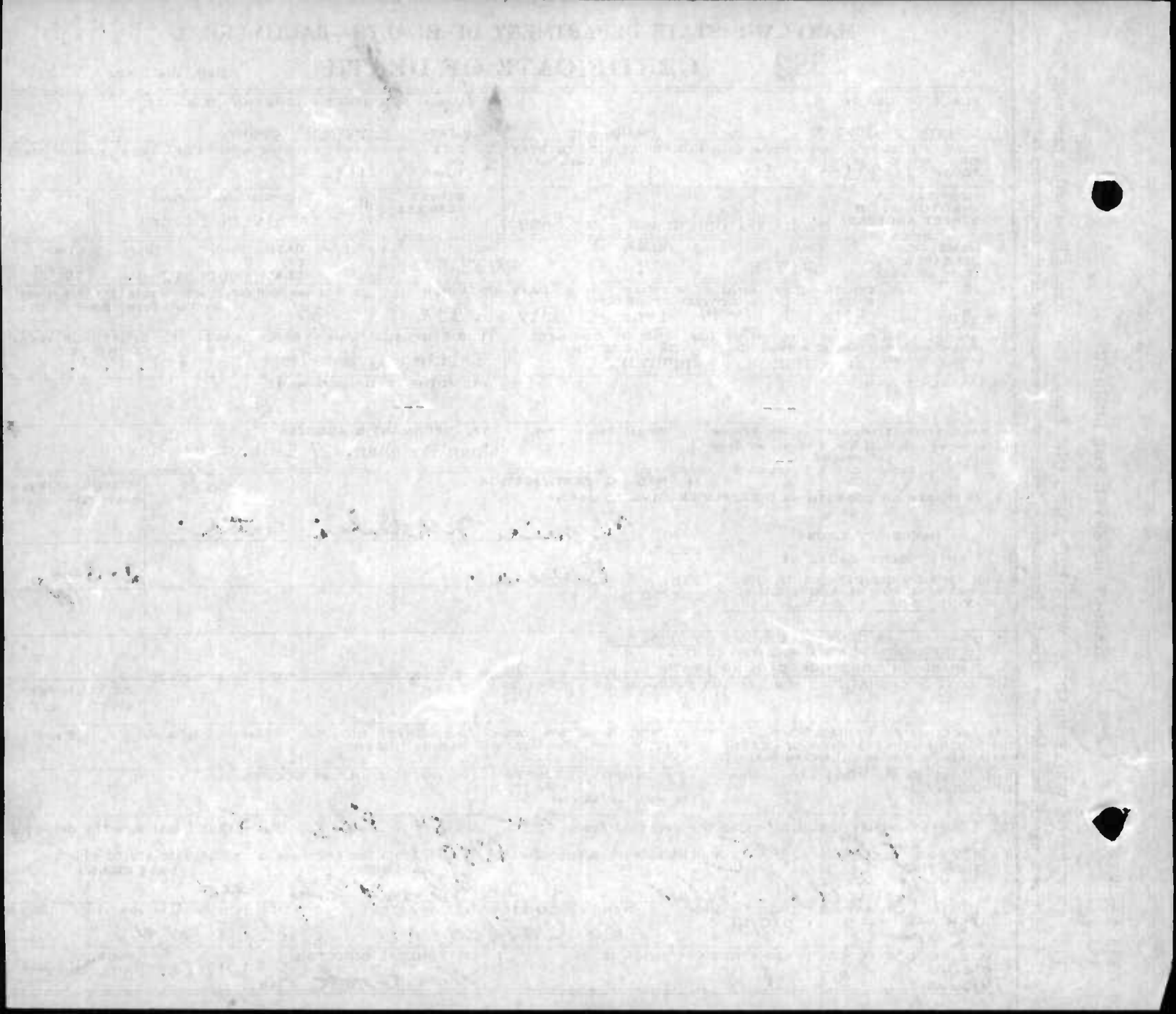
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Ellicott City	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home		STREET ADDRESS (If rural give location) Calvert Street	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
JOSEPH W. RENEHAN		February 3, 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: July 28, 1896
		9. AGE last birthday 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman		10B. KIND OF BUSINESS OR INDUSTRY: Insurance	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
13. FATHER'S NAME: ---		14. MOTHER'S MAIDEN NAME: ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) --		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: Joan Renehan, 2725 St. Paul Street	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Chronic Nephritis with			
ANTECEDENT CAUSE (S) DUE TO Edema			2-3 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar , 1954 to Feb 3 , 1955 that I last saw the deceased alive on Feb 1 , 1955, and that death occurred at 6:15 AM , from the causes and on the date stated above.			
SIGNATURE Robert B. Taylor		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY New Cathedral	
DATE THEREOF 2/5/55		LOCATION (City, town, or county) (State) Balto Md	
DATE REC'D BY LOCAL REGISTRAR February 5, 1955		REGISTRAR'S SIGNATURE RW	
		24. FUNERAL DIRECTOR Wm. Cooke, Inc.	
		ADDRESS 1217 St. Paul Street	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Robert Taylor 700 Carroll St

MU-5 7646



CERTIFICATE OF DEATH

Reg. Dist. No.

190

1693

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harward</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harward</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X <u>Jeannet</u>		<u>2.5 yrs.</u>		STREET ADDRESS <u>Jeannet</u>		(If rural give location) <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) <u>Henry</u> (Middle) <u>Sanders</u> (Last)				4. DATE OF DEATH: (Month) <u>FEB.</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Sept 19, 1878</u>	
9. AGE last birthday: <u>76</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>restaurant owner</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>				16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>C.W. Jess, Mission Rd, Jeannet, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
420.1 Immediate cause (a) <u>MYOCARDIAL INFARCTION</u>				2 WKS			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 FEB</u> , 19 <u>55</u> , to <u>7 Feb</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6 FEB</u> , 19 <u>55</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George E. Gulean</u> (Degree or title) <u>MD</u>				ADDRESS <u>Chbridge md</u> DATE SIGNED <u>7 Feb. 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 10, 1955</u>		<u>Parkwood Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REG'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 8 - 55</u>		<u>E. Bird Williams</u>		<u>De Witt Donaldson Laurel, Md</u>		<u>B.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 11 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01675

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALT. COCC</u> 3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shaffer's Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1236. Ostend ST.</u>	
3. NAME OF DECEASED (First) <u>Louis</u> (Middle) <u>Schoene, Sr</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>16,</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-22-75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.
13. FATHER'S NAME <u>Un Known</u>		14. MOTHER'S MAIDEN NAME <u>Un Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Louis Schoene, Sr ELLICOTT CITY, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>443X</u> Immediate cause <u>Cerebral embolism</u>		
(b) Antecedent cause(s) <u>Arteriosclerosis CV disease with hypertension</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>6 days</u> <u>5 yrs -</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1955, to Feb 16, 1955, that I last saw the deceased alive on Feb 15, 1955, and that death occurred at 3:00 m., from the causes and on the date stated above.

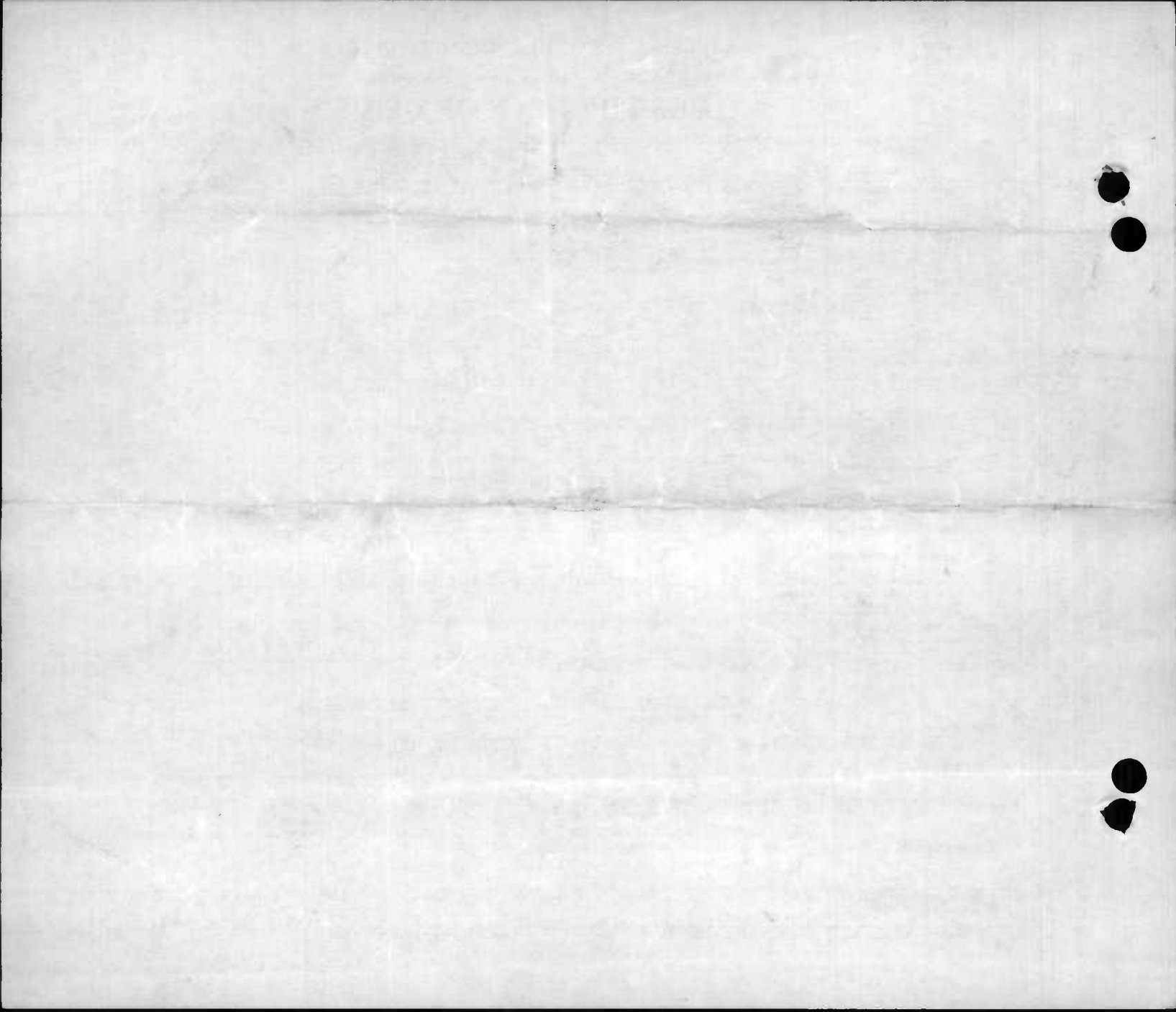
SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>19-55</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>Anne Arundel County, Md.</u>
DATE REC'D BY LOCAL REG. <u>2-15-55</u>	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>George L. Schwalb</u>	ADDRESS <u>2101 Frederick Ex.</u>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01676

1695

CERTIFICATE OF DEATH

Reg. Dist. No. 19.1

1. PLACE OF DEATH- COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Ellicott City		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Ellicott City		STREET ADDRESS Sylvan Lane	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		3. NAME OF DECEASED (Type or Print) Edward		(First) (Middle) (Last) Shipley		4. DATE OF DEATH 2 22 19 55	
5. SEX M		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 7/24/1865	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (State or foreign country) Carroll County		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wesley Shipley		14. MOTHER'S MAIDEN NAME Elisa Ann Shipley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Hilda Shipley, Ellicott City, Md.		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION NONE		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) GANGRENE, LEFT LEG

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) ARTERIO SCLEROSIS

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE		(Specify) NONE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?							

22. I hereby certify that I attended the deceased from Nov. 1954, to FEB. 1955, that I last saw the deceased

alive on FEB. 22, 1955, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 2/25/55		NAME OF CEMETERY OR CREMATORY St. Johns		LOCATION (City, town, or county) Ellicott City, Md.	
DATE REC'D BY LOCAL REG. Feb. 23, 1955		REGISTRAR'S SIGNATURE John B. Loughran Jr.		24. FUNERAL DIRECTOR F.C. Higinbotham		ADDRESS Ellicott City, Md.	

B. E. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. 3.

FEB 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

01677

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Howard	MARYLAND		STATE Md	COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
X TOWN N. Laurel			OR TOWN Baltimore 3Y01-4		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 1; 20 feet north of Whiskey Bottom Road			STREET ADDRESS (If rural, give location) 3733 Clarineth Road ✓		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) ROSALIE (Middle) SILVERMAN (Last)			(Month) 2-28-1955 (Day) 19 (Year)		
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH:		9. AGE last birthday: 24 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, (Specify if retired): Student		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Abe Silverman			14. MOTHER'S MAIDEN NAME: Lillian Hettleman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 218-26-1983	17. INFORMANT & ADDRESS: Lillian Silverman - Same		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Instant.....	
816X Immediate cause (a) Compound, Comminuted Fracture of Skull DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Rt. 1 U.S.	21c. (City or town) N. Laurel	(County) Howard	(State) Md	
21d. TIME (Month) (Day) (Year) (Hour) 2-28-55 9AM	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Head on collision with tractor trailer.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE George E. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-28-1955 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF 3-1-55	NAME OF CEMETERY OR CREMATORY Rosedale		LOCATION (city, town, or county) Balto Md	
DATE REC'D BY LOCAL REG. March 1, 1955	REGISTRAR'S SIGNATURE A. W. Hedrick	24. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Eutan Rd	

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

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1697

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Howard</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>	
CITY (if outside corporate limits, write RURAL OR TOWN) <i>Ellicott City</i>		LENGTH OF STAY (in this place) <i>2 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>O. Ella</i>		<i>03X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Schaffer's Home</i>				STREET ADDRESS (If rural give location) <i>Pleasant Hill</i>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>ADA GERTRUDE SIMS</i>				<i>Feb. 22, 1955</i>			
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>May 5, 1877</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Wearer (Retired)</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Woolen Mill</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME: <i>George W. Jones</i>				14. MOTHER'S MARDEN NAME: <i>Mary Proctor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>O. Ella, Md. Arthur Sims - Pleasant Hill</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Arteriosclerotic Vascular Disease</i>						<i>4 years</i>	
ANTECEDENT CAUSE (B) <i>260X</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes Mellitus</i>						<i>3 years.</i>	
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION: <i>None</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office hldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/29, 1952</i> , to <i>2/22, 1955</i> that I last saw the deceased alive on <i>2/21, 1955</i> , and that death occurred at <i>5³⁰ A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>George E. Buxton</i>		M. D. <i>Ellicott City, Md.</i>		DATE SIGNED <i>2/23/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-25-55</i>		NAME OF CEMETERY OR CREMATORY <i>Good Shepherd</i>		LOCATION (City, town, or county) (State) <i>Ellicott City, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb 23, 1955</i>		REGISTRAR'S SIGNATURE <i>John B. Loughman</i>		FUNERAL DIRECTOR <i>Boston Sons</i>		ADDRESS <i>Catonville Md.</i>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 28 1955

RECEIVED

MARYLAND

1698

STATE DEPARTMENT OF HEALTH

01679

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Highbridge, Laurel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Highbridge, Laurel</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>Sullivan</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>February 8</u> 1955	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 21, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>state road commission</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pleasant Valley, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Levin Sullivan, Laurel, Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
141X Immediate cause (a)..... <u>Malnutrition</u>		<u>10 wks</u>	
Antecedent cause(s) (b)..... <u>Carcinoma Tongue</u>		<u>1 year</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)..... <u>Metastases to Cervical Nodes</u>		<u>6 mos.</u>	
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension, Arteriosclerosis</u>		<u>10 yrs</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/27, 1946</u> to <u>2/8, 1955</u> , that I last saw the deceased alive on <u>2/7/55</u> , and that death occurred at <u>600 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. M. Warren MD</u> (Degree or title)		ADDRESS <u>Laurel</u> DATE SIGNED <u>2/8/55</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>2/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>	LOCATION (City, town, or county) (State) <u>Seagoville, Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 10 - 55</u>	REGISTRAR'S SIGNATURE <u>Frank Shipley</u>	24. FUNERAL DIRECTOR <u>Dr. W. H. Randall, Laurel, Md</u> ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1699

02754

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1 - Old Frederick Road</u>		STREET ADDRESS (If rural, give location) <u>Rt 1. Old Frederick Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rudolph</u> <u>Tragard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>5</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 17, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial Art</u>	9. AGE last birthday <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rudolph Tragard</u>		14. MOTHER'S MAIDEN NAME <u>Emma Brandt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ridgely Poe, Woodbine, Md.</u>			

13. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>1 Day</u>
Antecedent cause(s) (b) <u>Arteriosclerosis, Generalized</u>			<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 4, 1955, to Feb 5, 1955, that I last saw the deceased alive on Feb 4, 1955, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W.B. Culwell, M.D. mt. airy Feb 5, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>CREMATION</u>	<u>2-8-1955</u>	<u>Loudon Park</u>	<u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>2/21/55</u>	<u>E. Pearl Manager</u>	<u>C. M. Waltz, Winfield, Maryland</u>	

RECEIVED

MAR 22 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1700 Item 12, Film 177 2-15-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01680
 Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ellicott City</u>		LENGTH OF STAY (In this place) <u>2 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore, Md.</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highland Manor, Church St., Ellicott City, Md.</u>				STREET ADDRESS (If rural, give location) <u>2316 Ocala Avenue</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Samuel</u> <u>Warm</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>9</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH:		9. AGE last birthday: <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Mr. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Cleaning</u>		11. BIRTHPLACE (State or foreign country): <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>David</u>				14. MOTHER'S MAIDEN NAME: <u>Bessie Mintzer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Kirsch & Son - New York</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> DUE TO						<u>5 min.</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>George S. Binstorf</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/9/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>2-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>New York</u>		LOCATION (City, town, or county) (State) <u>N.Y.</u>	
DATE REC'D BY LOCAL REG. <u>10-55</u>		REGISTRAR'S SIGNATURE <u>H.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Jack Lewis Inc.</u>		ADDRESS <u>2100 Outlaw Pl</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01681

Reg. Dist. No. 191

1701

1. PLACE OF DEATH- COUNTY Howard CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City TOWN Ellicott City HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Road		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Howard CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City TOWN Ellicott City STREET ADDRESS (If rural give location) Old Annapolis Road	
3. NAME OF DECEASED (First) DORSEY (Middle) M. (Last) WILLIAMS		4. DATE OF DEATH (Month) February (Day) 18 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Unknown
9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Williams		14. MOTHER'S MAIDEN NAME Emily B. Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT John L. Clark, Atty., Ellicott City			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary Thrombosis			Immediate
Antecedent cause(s) (b) Arteriosclerotic Cardio-Vascular Disease			5 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Diabetes Mellitus			18 years
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June 4, 1950**, to **Feb. 18, 1955**, that I last saw the deceased alive on **Jan. 28, 1955**, and that death occurred at **5 P.M.**, from the causes and on the date stated above.

SIGNATURE William F. Hassaway		(Degree or title) M.D.		ADDRESS Ellicott City, Md.		DATE SIGNED 2/18/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 21, 1955	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) Baltimore, Md.		(State)	
DATE REC'D BY LOCAL REG. Feb. 19, 1955	REGISTRAR'S SIGNATURE John B. Cunningham		24. FUNERAL DIRECTOR Easton Sons, Catonsville 28, Md.		ADDRESS P.O. B. E. 2		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1955
BUREAU V. S.

RECEIVED
FEB 23 1955
BUREAU V. S.